Money Follows the Person Transition Screening Form

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Participant Name: _____

1. Do you want to live somewhere other than this facility? ☐ Yes ☐ No

Screening Type/Date (Check one box)	Gender:	Race:	MFP Target Population (Check one box):	Primary Disability (Check only one):
❑ Initial F2F Screening _____ (mm/dd/yyyy) ❑ F2F Re-screening _____ (mm/dd/yyyy) Screener's Name: _____ Screener's Contact: _____	❑ **M**ale ❑ **F**emale Ethnicity: ❑ **Not** Hispanic, Latino, Spanish ❑ Mexican, Mexi-can American ❑ Puerto Rican ❑ Cuban ❑ Another (Print Origin): _____	❑ White ❑ Black, African American ❑ American Indian or Alaska Native ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Pacific Islander ❑ Other (Print): _____	❑ OA-Older Adult (65+) ❑ PD-Physical Disability ❑ TBI-Traumatic Brain Injury ❑ DD-Developmental Disability	❑ D1-Cognitive (TBI, DD, dementia) ❑ D2-Hearing (deaf/HoH/H loss) ❑ D3- Mental/SPMI ❑ D4- Physical (mobility, stamina) ❑ D5- Vision (Blind/Low Vision) ❑ D6- N/A ❑ D7- DNK ❑ D8- Refused

Date of Initial MFP referral:	Referral Source:	Waiver Referral:	Refused/ineligible:
_____ (mm/dd/yyyy) Date of Waiver Referral: _____ (mm/dd/yyyy)	❑ RS1-Inpatient Facility ❑ RS2-MDSQ ❑ RS3-Self ❑ RS4-Family Member ❑ RS5-CIL, LTCO ❑ RS6-AAA/ADRC ❑ RS7-Waiver Case Mgr ❑ RS8-Personal Care Home ❑ RS9-Assisted Living Facility ❑ RS10-Legal Representative ❑ RS11-Other (specify): _____	❑ CCSP ❑ SOURCE ❑ ICWP ❑ NOW ❑ COMP ❑ Other Waiver (specify): _____	❑ in NF < 90 days ❑ no Medicaid ❑ didn't transition to qualified residence ❑ didn't cooperate in planning process ❑ no longer wished to participate ❑ Other (specify): _____

Primary Language:	❑ Deaf or Hard of Hearing
❑ American Sign Language ❑ English ❑ Spanish ❑ French ❑ Korean ❑ Other (specify): _____	Requires Interpreter: ❑ Yes ❑ No Interpreter:_____

Personal Data:

2. First Name:_____ MI:__ Last Name:_____

3. Date of Birth (mm/dd/yyyy) _____ SSN: _____--_____--_____

4. Medicaid # _____ Medicare # _____

5. Inpatient Facility Name: _____
   Facility Street Address: _____
   City: _____, Zip: _____ County: _____

MFP field personnel note: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.

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Participant Name: _____

6. Discharge Planner/Contact: _____ Phone : _____
7. Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Widowed ☐ Sep ☐ Other: _____

   (if applicable) Spouse Name and address: _____

   _____

8. Are you a veteran? ☐ Yes ☐ No. Did you serve during wartime? ☐ Yes ☐ No
9. Do you have a guardian: ☐ Yes ☐ No If yes, list name and contact information:

   _____

   (Screener note: Ask the person who they would like to include in the screening process—family members, friends, etc. If person has a guardian, stop the interview and reschedule the screening when these persons can participate).

Background Data:

10. What were the reasons you entered this facility?_____

    _____

11. How long have you lived here at this facility? _____ years _____ months
    (Screener note: to qualify for MFP, the person must have resided in the inpatient facility for a minimum of 90 consecutive days, short term rehab stays do not count).

    (Screener note: At this point in the screening interview, introduce, review and obtain signature on *Authorization for Release of Information* and *Informed Consent for MFP*).

12. Do you have any family living in this area? ☐ Yes ☐ No
    If yes, list name, phone number and address:

    _____

    _____

13. Are there family member(s) or friend(s) that would be interested in your move to the community? ☐ Yes ☐ No
14. May we contact these family member(s) or friends(s) to meet with you and us to discuss your move to the community? ☐ Yes ☐ No

    If yes, please provide their name(s) and telephone number(s): _____

    _____

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Participant Name: _____

Housing Section:

15. Where did you live before you came here? _____

    (Screener note: after the person answers, code the response by checking the box below: ☐ 01-own home, ☐ 02-family home, ☐ 03-apt/house leased by participant, ☐ 04-apt leased/assisted living, ☐ 05-group home/PCH, ☐ 06-Other (specify) _____

16. What Georgia County did you live in before you came here? _____

17. Do you want to return to (living situation in Q15)? ☐ Yes ☐ No

18. If yes, what prevents you from returning to (living situation in Q15)? _____

    _____

19. Do you have a home to move back into? ☐ Yes ☐ No

    If yes, the address (street, city, zip, county) of your home: _____

    _____

20. If applicable, does anyone live in your home? ☐ Yes ☐ No

    If yes, what are their names and relationship to you? _____

    _____

    (Screener note: discuss MFP qualified housing. Tell the candidate that while MFP will assist the person to locate qualified housing, the MFP program does not cover the cost of rent or utilities and that to participate in MFP, the person must enter qualified housing.

21. Which type of qualified housing are you interested in and why? _____

    _____

    (Screener note: after the person answers, code the response by checking the box below: ☐ 01-own home, ☐ 02-family home, ☐ 03-apt/house leased by participant, ☐ 04-apt leased/assisted living, ☐ 05-group home/PCH, ☐ 06-Other (specify) _____

22. What Georgia County do you prefer to live in? _____

23. Do you have someone you want to live with? ☐ Yes ☐ No

    If yes, list contact information _____

Waiver Service History:

24. Did you receive services in your home before coming here? ☐ Yes ☐ No

    If yes, what services: _____

25. Are you currently on a waiver waiting list for home & community based services? ☐ Yes ☐ No If so, which waiver? _____

26. Do you have a letter or contact information from the waiver? ☐ Yes ☐ No

    If yes, where is the letter or contact information and/or who can bring these to you? _____

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Participant Name: _____

Financial Data:

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent will allow you to obtain and review facility records).

25. Income and Resources:

SOURCE	MONTHLY AMOUNT	PAYEE
☐ **SSDI** ☐ **SSI** ☐ **SS Retirement**		
PENSION BENEFITS		
TRUST PROCEEDS		
INHERITANCE		
VETERAN'S COMPENSATION		
CASH		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
SAVINGS ACCOUNT(DESIGNATED BURIAL)		
CEMETERY PLOT		
RAILROAD RETIREMENT		
LIFE INSURANCE		
CERTIFICATE OF DEPOSIT		
OTHER (SPECIFY)		
OTHER (SPECIFY)		
OTHER (SPECIFY)		
OTHER (SPECIFY)		

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Participant Name: _____

27. Who is paying for your stay here? _____

    _____

26. Are you Medicaid eligible, but subject to transfer of asset penalty?
    ☐ Yes ☐ No ☐ DNK (Do Not Know) (Screener note: check facility records)

Health Care Needs:

27. How would you describe your primary disability or limitation? _____

    _____

    Screener note: After the person provides a primary disability, confirm that the response fits into one of the following categories and check the box: ☐ D1- Cognitive (TBI/DD, dementia), ☐ D2- Hearing (Deaf/HoH/Hearing loss), ☐ D3- Mental/SPMI, ☐ D4- Physical (Mobility/Dexterity/Stamina), ☐ D5- Vision (Blind/Low Vision), ☐ D6- Not Applicable, ☐ D7- DNK, ☐ D8- Refused

28. Who is your doctor here at this facility? _____

29. Do you have a primary care doctor or clinic in the community? ☐ Yes ☐ No

    If yes, list contact information? _____

    _____

30. Do you need help taking your daily medications? ☐ Yes ☐ No

    Describe assistance needed: _____

    _____

31. What specialized medical equipment (DME) and assistive technology devices do you use?

    _____

    _____

    _____

32. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?

    _____

    _____

    _____

    _____

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Participant Name: _____

34. Functional Needs -

See KEY below for instructions to complete:

Function: Ask, "Do you need help with (activities below)? (observe person doing activity when possible)	**Impairment:** If assistance needed, check yes	**Unmet Need:** Ask: Do you have an **unmet need for** help with (activities) _____ in the community?	**Comments: Identify sources of assistance in the community, resources, assistive technology, DME used. Describe special needs and circumstances that should be taken into account when developing a plan for services and supports**
1. Eating	☐ Yes ☐ No	☐ Yes ☐ No	
2. Bathing	☐ Yes ☐ No	☐ Yes ☐ No	
3. Grooming	☐ Yes ☐ No	☐ Yes ☐ No	
4. Dressing	☐ Yes ☐ No	☐ Yes ☐ No	
5. Transferring	☐ Yes ☐ No	☐ Yes ☐ No	
6. Continence	☐ Yes ☐ No	☐ Yes ☐ No	
7. Managing Money	☐ Yes ☐ No	☐ Yes ☐ No	
8. Telephoning	☐ Yes ☐ No	☐ Yes ☐ No	
9. Preparing Meals	☐ Yes ☐ No	☐ Yes ☐ No	
10. Laundry	☐ Yes ☐ No	☐ Yes ☐ No	
11. Housework	☐ Yes ☐ No	☐ Yes ☐ No	
12. Outside Home	☐ Yes ☐ No	☐ Yes ☐ No	
13. Routine Health	☐ Yes ☐ No	☐ Yes ☐ No	
14. Special Health	☐ Yes ☐ No	☐ Yes ☐ No	
15. Being Alone	☐ Yes ☐ No	☐ Yes ☐ No	
KEY Assistance Needed in the Community Ask: **Do you need help with (activities listed above #1-15)?** When appropriate, observe the person in the activity.		**Unmet Need for Care** – when person returns to the community Ask: **When you return to the community, do you have an unmet need for someone to help you with _____ (activities listed above #1-15)?** If participant has assistance of family/friend/caregiver or assistive device, the answer would be **NO.** If participant **has no assistance**, the answer would be **YES (there is an unmet need for care).** Note observations.	

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35. Home Community Based Service (HCBS) referral to:
    - ☐ CCSP (AAA/Gateway)
    - ☐ SOURCE (SOURCE Case Management)
    - ☐ Independent Care Waiver (ICWP) (GMCF)
    - ☐ NOW/COMP Waiver (Regional DBHDD or DBHDD-DDD/MFP Office)
    - ☐ State Plan Services (list) _____
    - ☐ Non Medicaid HCBS (specify) _____

36. Date of referral to waiver _____ (mm/dd/yyyy).

37. Date HCBS application submitted: _____ (mm/dd/yyyy)

38. Date HCBS waiver assessment completed: _____ (mm/dd/yyyy)

39. I DO NOT wish to participate in MFP:

    Signed: _____ Date: _____

Document Checklist:

(Screener note: attach the following documents. Send these copies and copy of completed Screening Form with referral to AAA/Gateway and/or GMCF).

- ☐ Copy of *MFP Informed Consent for Participation*
- ☐ Copy of *Authorization for Use or Disclosure of Health Information*
- ☐ Copy of Medication Administration Record (MAR) or list of current medications
- ☐ Copy of State Medicaid Card
- ☐ Copy of Medicare Card
- ☐ Copy of Social Security Card
- ☐ Copy of Legal documents that cover guardianship (on file at institution)
- ☐ Copy of Documents that cover Power of Attorney (on file at institution)
- ☐ Nursing Home face-sheet
- ☐ Other (Specify) _____

Notes: _____

_____

MFP Field Personal Contact Information

Name:_____ Date: _____

Phone: _____ Email: _____

MFP field personnel note: the *MFP Transition Screening Form* must be submitted even when the person being screened refuses participation or is found to be ineligible. If the person refuses participation, be sure Question 39 is signed.

MFP field personnel note: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.